Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Person Centered Plan

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	**Registered nurse, licensed to practice in the State**
☐	**Licensed practical or vocational nurse, acting within the scope of practice under State law**
☐	**Licensed physician (M.D. or D.O)**
☐	**Case Manager** (qualifications specified in Appendix C-1/C-3)
X	**Case Manager** (qualifications not specified in Appendix C-1/C-3). *Specify qualifications*:

Coordinators of Community Services (case managers) qualification requirements are specified in COMAR regulations which include the following:

1. Have at a minimum, a bachelor's degree from an accredited education program in a human services field;
2. Demonstrate skills and working knowledge in areas including:
   a. Negotiation and conflict management;
   b. Crisis management;
   c. Community resources including generic programs, local programs, State programs, and federal programs and resources;
   d. Determining the most integrated setting appropriate to meet the individual's needs;
   e. Coordinating and facilitating planning meetings;
   f. Assessing, planning, and coordinating services;
   g. Assisting individuals in gaining access to services and supports;
   h. Monitoring the provision of services to individuals;
   i. Regulations governing services for individuals with developmental disabilities.
3. All DDA-licensed Coordination of Community Service providers shall ensure through appropriate documentation that staff receive training required by DDA including person-directed and person-centered supports focusing on outcomes.
4. Coordinators of Community Service education and experience requirements may be waived if an individual has been employed by a DDA-licensed Coordination of Community Service agency as a coordinator for at least 1 year as of January 1, 2014.

An individual is ineligible for employment by a Coordination of Community Services provider, agency, or entity in Maryland if the individual:

1. Is simultaneously employed by any MDH-licensed provider agency;
2. Is on the Maryland Medicaid exclusion list;
3. Is on the federal List of Excluded Individuals/Entities (LEIE);

	4. Is on the federal list of excluded parties as maintained by the System of Award Management (SAM.GOV); 5. Has been convicted of a crime of violence in violation of Criminal Law Article, §14-101, Annotated Code of Maryland; 6. Violates or has violated Health-General Article, §7, Annotated Code of Maryland; or 7. Has been found guilty or been given Probation Before Judgment for a crime which would indicate behavior potentially harmful to individuals receiving services, as documented either through a criminal history records check or a criminal background check, pursuant to Health-General Article, §19-1902, et seq., Annotated Code of Maryland; and regulations. Coordinators of Community Services must possess the skills necessary to coordinate planning meetings; create person-centered plans; negotiate and resolve conflicts; assist individuals in gaining access to services and supports; coordinate services and monitor the provision of services to individuals. Coordinators of Community Services must complete training on using the framework for charting the Life Course. The framework helps individuals and families of all abilities and at any age or stage of life develop a vision for a good life, think about what they need to know and do, identify how to find or develop supports, and discover what it takes to live the lives they want to live. It helps individuals and families look ahead to start thinking about life experiences now that will help move them toward an inclusive, productive life in the future.
☐	**Social Worker** *Specify qualifications:*
☐	**Other** *Specify the individuals and their qualifications:*

b. Service Plan Development Safeguards.

Select one:

X	**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
○	**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Participants and family members are the central members of the team responsible for developing a person-centered plan and are provided with written and/or oral information about DDA services and the process of developing a plan. Participants and families have the support of a trained Coordinator of Community Service to assist them by facilitating the team meeting and creating a Person-Centered Plan.

(b) Participants and families are provided with information about their right to invite family members, friends, self advocates, coworkers, professionals, and anyone else they desire to be part of team meetings and/or their circle of support, and are encouraged to involve important people in their lives in the planning process.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Participants and family members are the central members of the team responsible for planning and developing a person-centered plan. They are provided the option to direct and manage the planning process. Participants can utilize a variety of person-centered planning methodologies such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long-Term Services and Supports – Needs Template and Before and After Integrated Supports, Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, or an equivalent person-centered planning strategy. The family, friends, neighbors, professionals, and others important to the person can be invited to the meeting based on the person's preferences. Coordinators contact the participant to obtain the person's preferences for the best time and location of the meeting. Meetings are held at participants' homes, jobs, community sites, day programs, or wherever he or she feels most comfortable reviewing and discussing his/her plan. The plan is developed as part of the waiver application process and updated at least annually or when there are changes to circumstances or services.

(b) To support the service plan development process, the Health Risk Screening Tool (HRST) and Support Intensity Scale (SIS) are conducted in addition to obtaining a variety of information and assessments about the participant's needs, preferences, life course goals, and health from other sources. The SIS measures the individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The HRST assesses the participant's health and safety needs. Areas of assessment and planning may include but are not limited to: community safety, health/medical, sexuality/relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, etc. As part of the process of developing the Person-Centered Plan, the Coordinator of Community Services also gathers information from the participant, his/her family, friends, and any

other individuals invited to participate regarding the participant's goals, needs, preferences, health status, risk factors, etc. They review formal health, developmental, communication, and behavioral assessments conducted by physicians, mental health professionals, behavioral specialists, special educators, and other health professionals (e.g., speech, OT, PT), as appropriate.

(c) The Coordinator of Community Services shares information with the person and his/her family about available waiver services during initial meetings, quarterly monitoring activities, and annual plan meetings. Participants and/or their representatives are also provided information on how to access, via the internet, a comprehensive listing of DDA services (including all waiver-covered services) and providers and are assisted in integrating the delivery of supports needed. If internet access is not available, the participant and his/her family are provided with a resource manual.

(d) An individual-directed, person-centered planning approach is used to identify strengths, needs, preferences, access paid and non-paid supports, health status, risk factors, etc. of the person based on information gathered from the participant, his/her circle of support (family and friends), as well as assessments, observations and/or interviews. Based on a person-centered planning approach, a Person-Centered Plan is developed that includes the natural; informal; local, State, and federal programs; and waiver services to be provided. The services support focus areas to support the individual to live successfully within his/her home and community, to address personal goals, address health and safety factors, and the need for training for the participant, his/her family, and staff implementing the Person-Centered Plan.

(e) The person's Coordinator of Community Services is charged with assisting the participant in coordinating generic resources, natural supports, services available through other programs, Medicaid State Plan services, and waiver services. The Coordinator of Community Services provides assistance, as necessary, to help the participant connect with this array of services and supports and ensure their coordination. The Person-Centered Plan remains the focal point of coordinated services - a working plan that details the individuals plan towards achieving and maintaining a good quality of life, addressing health, safety and security, community integration, social life, spirituality, citizenship and advocacy.

(f) Roles and responsibilities for services and supports are outlined in the Person-Centered Plan. The Coordinator of Community Services has responsibility for monitoring implementation of the Person-Centered Plan on an ongoing basis through telephone, e-mail, and face-to-face contacts. The Coordinator of Community Services ensures that the participant's health and safety needs continue to be met. In addition, when a change in health status occurs, the Coordinator of Community Services determines the need for service changes to take place. They also make sure that services are delivered in the manner described in the Person-Centered Plan, and that the participant's goals, needs, preferences, etc. are being addressed and met.

(g) At least annually, or when there is a change in a participant's needs, health status or circumstances, the participant, his/her family, and his/her self-selected team must come together to review and revise the Person-Centered Plan. This means that a participant's Person-Centered Plan must remain current and reflect the needs of the person. Person-Centered Plans are modified through the team planning process with direction from the participant, with support from his/her family, and with input from his/her Coordinator of Community Services, community provider staff and all other invited team members as requested by the participant.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

As part of the person-centered planning process and development of the Person-Centered Plan, the participant's health and safety needs are assessed by the team. Areas of assessment and planning may include but are not limited to: community safety, health/medical, sexuality/relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as appropriate to the age and circumstance to the individual. The family is a key source of information on the risk assessment and mitigation when supporting children.

To promote optimum health, to mitigate or eliminate identified risks and to avert unnecessary health complications or deaths, the electronic Health Risk Screening Tool (HRST) is required for all participants annually. The HRST is a web-based screening instrument designed to detect health destabilization early and prevent preventable deaths. It is a reliable, field-tested screening tool that consists of 22 rating items, divided into 5 health categories. The outcome of scoring all 22 rating items is an objective Health Care Level that represents the overall degree of health risk and destabilization of the person. Since each of the 22 rating items receives its own score, the level of health risk can be determined on each of the items as well. Once an individual is fully screened, the HRST produces Service and Training Considerations that can be used by staff and families. Service Considerations describe what further evaluations, specialists, assessments or clinical interventions may be needed to support the individual based on the identified issues.

Through the use of the supporting families' tools such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long- Term Services and Supports – Needs Template and Before and After Integrated Supports, individuals and families will also assess other areas of risk for the individual in addition to medical concerns.

Individualized risk mitigation strategies are incorporated into the person-centered plan and are done in a manner sensitive to the participant's and his/her family preferences. Risk mitigation strategies may include participant, family, and staff training; assistive technology; back-up staffing and emergency management strategies for various risks such as complex medical conditions, people at risk or have a history with elopement, or previous victim of abuse, neglect, and exploitation.

Risk mitigation strategies, including back-up plans, are discussed as part of the team meeting, are based on the unique needs of the participant, and his/her family, and must ensure health and safety while affording a participant the dignity of risk. Coordinators of Community Services assist participants in the development of back-up plans which are incorporated into the person-centered plan and service record. In addition, all DDA-licensed service providers must have a system for providing emergency back-up services and supports as part of their policies and procedures, which are reviewed by DDA and Office of Health Care Quality (OHCQ).

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The Coordinator of Community Services provides information to participants, family members, and other identified representatives regarding waiver services including self-directed options and community service providers. The coordinator assists the individual and family with integrating the delivery of supports.

Participants utilizing the traditional services delivery method are informed of DDA licensed providers for which they are able to explore, interview, and exercise their choice. Coordinators of Community Services can assist the participant in scheduling visits with providers, provide a listing of providers, and also share the DDA website address that also lists the providers.

Participants are encouraged to learn about multiple providers and meet and interview staff regarding services prior to selecting their provider agency. Potential providers can discuss how they can support the individuals and families in a way that meets their needs, in a manner that meets their preferences (culturally and otherwise), and in alignment with the individuals' and families' goals.

For services and programs at a specific location, individuals and families can request a tour, ask questions, and observe classes and programs in order to make an informed choice.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The SMA ensures compliant performance of this waiver by delegating specific responsibilities to the Operating Agency (DDA) through an Interagency Agreement (IA). All Person-Centered Plans are submitted to DDA for review and approval prior to service initiation via a web-based system. The DDA reviews the Person-Centered Plans and supporting documentation to ensure compliance with policy and regulations.

In addition, the SMA monitors service planning activity through the quality performance measures. The SMA also retains the right to review and modify service plans at any time.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

○	**Every three months or more frequently when necessary**
○	**Every six months or more frequently when necessary**
X	**Every twelve months or more frequently when necessary**
○	**Other schedule** *Specify the other schedule*:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies)*:

☐	**Medicaid agency**

X	**Operating agency**
X	**Case manager**
☐	**Other** *Specify:*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) Coordinators of Community Services are responsible for monitoring the implementation of the service plan and participant health and welfare. They are required to conduct quarterly monitoring activities which include whether people are receiving services as specified in the plan; whether staff ratios are provided as specified in the plan; whether there is an emergency plan; and whether there were any incidents during the reporting period. Their findings and appropriate actions taken to remediate concerns are documented.

(b) Coordinators of Community Services conduct monitoring and follow-up activities through telephone conferences, emails, and face-to-face meetings with the participant and his/her family. Monitoring and follow-up activities include:

1. Assessment of:
   a. Services being rendered as specified in the Person-Centered Plan;
   b. The participant's current circumstances;
   c. Progress toward goals and intended outcomes;
   d. The participant's referral status; and
   e. The participant's needs and supports to maintain eligibility for Medicaid, waivers, DDA services, and any other relevant benefits or services;
2. Identification of new medical, health services, or other needs;
3. Requests for service change and modifications to meet health and safety needs, preferences, and goals;
4. Identification of new support or resource options;
5. Review and, if necessary, revision of the plan for emergencies;
6. Monitoring of any and all reportable incidents as defined in DDA's reportable incident policy; and
7. Application or re-application for necessary programs or services to prevent or remedy a gap in eligibility.

(c) Coordinators of Community Services perform face-to-face monitoring and follow-up activities a minimum of a quarterly basis in different services delivery settings; at least one time in each service delivery setting; and more frequently as needed.

b. Monitoring Safeguards. *Select one:*

X	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the**

	participant.
○	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.** The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-assurances:

a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*SP – a - Number and percent of waiver participants who have their individually chosen assessed needs addressed in the service plan through waiver funded services or other funding sources or natural supports.*
Data Source *(Select one) (Several options are listed in the on-line application): DDA*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	*X Representative*

				Sample; Confidence Interval =95
	☐ Other Specify:	*☐ Annually*		
		☐ Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

b. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*SP – b- Number and percent of service plans reviewed and updated before the waiver participant's annual review date.*
Data Source *(Select one) (Several options are listed in the on-line application): DDA*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

c. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*SP – c - Number and percent of waiver participants who are receiving service in the type, scope, amount, frequency, and duration specified in the Person Centered- Plan (PCP).*
Data Source *(Select one) (Several options are listed in the on-line application): DDA*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval = 95*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Performance measure (button to prompt another performance measure)

d. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*SP – d -Number and percent of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers*
Data Source *(Select one) (Several options are listed in the on-line application): DDA*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

DDA's Quality Enhancement staff provides oversight and insure compliance related to waiver participants. DDA's Coordination of Community Services staff provides technical assistance and support on an ongoing basis to Coordination of Community Services and will address provide specific remediation items. Based on the items, a variety of remediation strategies may be used including conference call, letter, in person meeting, and training. Remediation efforts will be documented in the provider file.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	**Responsible Party** *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **State Medicaid Agency**	☐ **Weekly**
	X Operating Agency	☐ **Monthly**
	☐ **Sub-State Entity**	**X Quarterly**
	☐ **Other** Specify:	☐ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

X	**No**
○	**Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.